CHAPTER 21

# Family Discord

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Family discord can affect the health of individuals as well as the function of family life. Often symptoms and signs of family discord are subtle and manifest as vague illness or behavior in family members. Family discord must be on the differential diagnosis for many behavioral and psychiatric problems. Helping restore families to healthy functioning often improves the health and quality of living for all members of the family.

## ADOLESCENT ISSUES

Adolescent medicine presents a unique challenge to the family practitioner. Preventive services have been provided for years, through vaccines and counseling regarding healthy lifestyle choices. It is routine to screen children for cardiovascular risk factors and obesity, as well as for sexual activity and emotional problems (see Chapter 25).

### PSYCHIATRIC ISSUES IN ADOLESCENT MEDICINE

Signs

- Sexual activity as marker: Involuntary sexual activity is reported by 74% of sexually active girls younger than 14 and 60% of sexually active girls 14 and older +++
- Depression
  - Studies have suggested an association between having a sexually transmitted disease (STD) and depression in adolescents. (see http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_10.pdf).
  - Depression is an important diagnosis in adolescence.
- There has been an association between SSRI use and adolescent suicide.

### SAFETY ISSUES

- Sports evaluation
  - Screen in an attempt to decrease incidence of sudden death or cardiovascular diseases.

- Seatbelt use and helmet use for bicycles and motorcycles should be reinforced.
- Discourage drinking and driving.
- Assess for safety.
  - Screen for weapons use in the home.

## SEXUAL ACTIVITY AND ADOLESCENT HEALTH

- Approximately 45% of high school girls and 48% of high school boys have had sex. +++
- Average age of first intercourse is 17 for females, 15 for males.
- STDs are better prevented than treated.
- Condoms help prevent both pregnancy and STDs.
- Postcoital contraception is an option that can be offered to patients within 72 hours of intercourse.
- There are 900,000 teenage pregnancies per year.
- Approximately 50% of adolescent pregnancies occur within the first 6 months of initiating intercourse. +++
- The United States has the highest adolescent birth rate compared to Europe.

## DOMESTIC VIOLENCE

Domestic violence or intimate partner abuse is a pervasive health problem in the United States. In 2000, the CDC reported that 25% of women experience physical and or sexual abuse over a lifetime compared with a 7.6% lifetime prevalence for men. The National Violence Against Women Survey reports 4.8 million women have experienced intimate partner violence compared with 2.9 million men; 6% of all pregnant women experience battering, and approximately 1200 women die in homicides each year.

For the purpose of screening and patient care, domestic violence and intimate partner violence are defined as a pattern of violent and coercive behavior in which one partner in an intimate relationship controls another through force, intimidation, or threat of violence. Practitioners must be attuned and assess for problems related to stalking, intimidation and threats, psychologic abuse including social isolation, and economic deprivation. The patterns include inflicted physical injury and sexual abuse, but are not limited to outward signs of abuse. Indirect health consequences may be related to the psychologic effects of abuse.

### Symptoms

- Homicide
- Broken bones
- Injuries often to the head, face, neck, thorax, breast, and abdomen +++
- Contusions, scratches
- Ecchymosis on the neck

- Multiple strangulation attacks lead to injuries to the neck and throat and neurologic disorders.
- STDs, vaginal injuries

### Signs

- Suicide attempts
- Anxiety (panic, posttraumatic stress, agoraphobia)
- Depression
- Fatigue
- Somatic complaints (chronic)
- Headaches
- Alcohol and substance abuse
- Abdominal pain (chronic)
- Visits to the physician can range from frequent abundance, to poor, lacking follow-up appointments.
- A partner who appears to be controlling and will not permit the physician to examine the patient alone may be an indication of abuse.

### Signs During Pregnancy

- Maternal injury and death
- Late onset to health care and or inadequate follow-up for prenatal care
- Inadequate weight gain
- Placental abruption, preterm labor, fetal injury and fetal demise
- Increased risk for sexual assault and sexually transmitted disease
- Substance abuse

### Workup

- Radiographic imaging if suggested by history and if suggestive necessary orthopedic referral
- Genital examination/STD screening
- Careful skin examination (staging of contusions)
- Digital photography for documentation

### Comments and Treatment Considerations

Treat all acute injuries. Provide nonjudgmental support; people stay with abusive partners for a variety of complex reasons including fear, positive connection to abuser during times of calmness, financial and cultural reasons, family, hope for change, and isolation.

Have frequent visits: Even if the patient has left an abusive partner continue to inquire about threats and danger. Discuss orders of protection. Provide information about local domestic violence shelters and services. Repeat domestic violence screening more than once during the course of pregnancy any time indicators are present and again at postpartum visit.

Discuss a safety plan. Have the patient pack a bag with clothes, toys, or special items for children to evade imminent danger. Refer to mental health counselor or domestic violence service agency.

- Emergency housing
- Support group
- Legal advocacy

Cautiously provide psychopharmacologic therapy for comorbid mental health problems; symptoms are unlikely to abide until abuse discontinues.

Perpetrator of the violence should be referred to batterers group or individual counseling.

## SCREENING INTERVIEW

RADAR screening method:

- *R*outine screening: ask about domestic violence during:
  - New patient examinations
  - Annual examinations
  - Family planning visits
  - Episodic visits that present indicators of abuse
- *A*sk direct questions about abuse and acknowledge the patient's experience.
- *D*ocument your findings.
- *A*ssess for the patient's safety.
- *R*eview options and make appropriate referrals.

## CHILDREN AND DOMESTIC VIOLENCE

Children who witness domestic violence are prone to adverse psychologic and health consequences. Children who are exposed to domestic violence are at higher risk for smoking, alcoholism, substance abuse, obesity, depression, pulmonary disease, hepatitis, heart disease, and suicide.

### Symptoms

- Psychosomatic symptoms
- Depression
- Anxiety
- Low self-esteem
- Eating disorders
- Effect on early brain development

### Signs

- Injury ++
- Trauma
- Child abuse or neglect +++
- Fear
- Withdrawal
- Depression
- Suicide tendencies
- Sleeplessness

### Workup

- Treat injuries and acute trauma.
- Assess safety and make referral to ensure child is safe; a protection referral is needed if the child is harmed.
- Conduct an in-depth clinical interview to determine if the child has witnessed violence.
- Be acquainted with local laws regarding child abuse. Many states require a report to child protection services when a child witnesses domestic violence.
- Refer to a mental health counselor.

## END OF LIFE

End-of-life issues present difficult challenges for patients, family members, family practitioners, and staff. The complex and emotional nature of mortality is further compounded by ethical and legal issues, individual and family preparations for the impending death, and timeframe of onset of terminal illness or condition to death.

### Comments and Treatment Considerations

Due to cultural, generational, and age differences and types of illnesses and conditions that patients face at the end of life, there is no absolute formula on what a person's end of life should look like. Patients should be involved in decision making and have the right to refuse care in accordance with law. Pain management is also a goal and right of the patient.

There are several recommendations: relieve suffering, maintain patient dignity, and provide palliative care for dying patients and their families.

### PALLIATIVE CARE

The primary goal is to provide comfort and quality of life to patients rather than to cure a disease or prolong life. Dying is regarded as a normal process. However, the patient may be receiving aggressive treatments and therefore may also include care that is disease oriented.

### HOSPICE CARE

The primary goal is to provide care to dying patients using a multidisciplinary team approach. Such care is appropriate for patients with a life expectancy of less than 6 months and for patients willing to give up disease-focused treatments and aggressive care, including hospitalizations.

When considering hospice care, maximize quality of life offered by using services such as hospice or palliative care. Address safety and comfort with the patient as well as the unique needs of the patient, such as children and the patient's family. Respect cultural, spiritual, and religious preferences.

## PAIN AND SYMPTOM MANAGEMENT

The patient has a right to pain and symptom management. Assess for pain and symptoms, including diagnosis, presenting problems, current treatment and medication, existing pain management regimen, patient and family concerns/preferences, and patient/family values concerning pain management. Use a pain assessment scale to record baseline.

Create a pain management plan and educate the patient about pain management, including home care. Monitor the patient's response to medications, pain relief compared to baseline from scale, side effects and reactions, level of sedation, and satisfaction with the intervention. If pain is not satisfactorily managed, refer to other pain management resources.

## ADVANCE DIRECTIVES

Advance directives are formal documents that guide health care decisions if a patient becomes sufficiently incapacitated to speak for him- or herself and include a living will, five wishes document, and/or health care proxy (durable power of attorney).

Support patients and their family through communication and presence. Be present through transition: many patients report a lack of physician presence and communication during important end-of-life decisions and discussion.

Have ongoing contact with the patient through scheduled meetings or facilitate meetings between patients and their primary care provider and/or specialist. Communication is vital and a family conference may be appropriate. Address goals of care and changes in patient status. Discuss family conflict surrounding end-of-life issues (patient may need referral to a mental health practitioner). Discuss care options and family beliefs (including spiritual and cultural).

Be available to debrief with the family after the death of the patient.

## TREATMENT TEAM CONFERENCE

Discuss coordination of care. Discuss plan for managing the patient or family members who may be seen as “difficult.” Discuss other pertinent patient care issues, such as complications due to mental health issues.

## GRIEF AND LOSS CONSIDERATIONS

Grief and loss are normal reactions to death and dying. Discuss grief and loss with the patient and family. Refer to a mental health practitioner as needed. Distinguish between normal feelings of grief and clinical depression, anxiety, and other treatable compounding mental health disorders.

## PSYCHIATRIC CONSIDERATIONS

There may be an overlap of symptoms among depression, anxiety, and terminal illness, such as trouble sleeping, fatigue, and poor appetite. Symptoms that are out of proportion given the patient's context should be considered. Refer to a mental health practitioner.

## CHILDREN AND DYING

The event of dying or preparing for death is unique when applied to children in that it is not a normative life-cycle event. Many of the emotions are likely to be more intense for all involved in care.

Due to prognostic ambiguity of childhood illnesses that threaten life, palliative services should be offered early to aid the child and family in experiencing a “good death.” Help parents and caregivers understand that palliative care does not necessarily mean that a search for a cure has been abandoned.

Follow pain and symptom relief procedures. As the family physician, support the family and patient and find additional support for the family as needed.

# MARITAL STRIFE

According to the CDC, in 2009, the marriage rate was 6.8 per 1000 population, and the divorce rate was 3.4 per 1000 population for the 44 reporting states and Washington, DC.

Overall, 50% of first marriages end in divorce. The rate of divorce for second marriages increases 10%. Couples who experience marital difficulties are more prone to physical illness with an increased rate of 35%. Furthermore, there is a decrease of up to 4 years in life expectancy. Psychologic health for the individuals and the family members is also affected by marital distress.

Children in families with marital strife are more prone to infectious diseases due to elevated stress hormones. Increased depression, substance abuse, increased acting-out behavior, and poor school performance may also occur.

### Symptoms
- Depression +++
- Anxiety ++
- High blood pressure
- Heart disease
- Substance abuse
- STDs

### Signs
- Tension is high.
- Verbal or physical fights may ensue.
- Lack of regular affection and positive regard
- Decrease in sexual and nonsexual, affectionate contact
- The couple's mode of emotional communication is characterized by:
  - Criticism (feedback is often delivered in a harsh manner right from the start). The individual or pair has global negative critical feelings about the partner's character or personality.
  - Contempt
  - Defensiveness
  - Stonewalling (distance in which an individual ignores the other)

### Workup
- Rule out any medical cause for the symptoms (i.e., depressed mood due to thyroid function).
- A sexually transmitted disease screening and examination should be involved for STD symptoms or disclosure of extramarital sexual affairs.
- An in-depth clinical biopsychosocial interview should identify the marital difficulties. Questions should include the following:
  - How do you deal with conflict with your partner?
  - Do you avoid conflict?
  - Do these interactions become destructive and disrespectful?
  - Do you or your partner become physically abusive?
  - Do you think there are differences in your relationship since your marriage or commitment?
  - Is there emotional distance in the relationship? Do you talk with each other about concerns, goals, and aspirations?
  - Do you spend less time with each other? Do you feel taken for granted by your partner?
  - Is the relationship passionate and affectionate? Is there a decrease in sexual desire?
  - Do you and your partner enjoy each other's company? Do you have fun together?
  - As a couple, how have you adjusted to major changes in your relationship? (job loss, illnesses, birth of a child)
  - Are there recent disturbing stressors that have occurred in your relationship? (substance abuse, financial strain, extramarital affair)
  - Do you and your partner agree on child rearing, values, spirituality, finances, and relationships with friends and relatives?

- Do you have a partnership and work together as a team? Is there mutual decision making, planning and sharing responsibilities for household, child care, and family responsibilities?
- Did you have difficulties from your past childhood that interfere with your relationship in the present?

## Comments and Treatment Considerations

Efforts to repair distance and tension are often unproductive. These efforts include positive attention measures for the purpose of reconnection such as compliments, humor, and apologies. The couple lacks positive feelings, friendship, respect, affection, and admiration for each other. When inquiring about their dating history and/or wedding memories, the reports are often negative.

Distance prevails as a means of coping with the marital strife. As the couple becomes more distant from each other, it creates a lack of emotional connection, loneliness, and often leads to living separate lives. Consequently, one or both members of the relationship turn toward outside areas for fulfillment. This may take the form of workaholism, alcoholism, substance abuse, and attention only to the children or outside activities and friends. For some, emotional connection and intimacy are sought outside the relationship in extramarital affairs.

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